Mark Sweeney, DDS and Associates

Name: ______________________________ **I prefer to be called:** _______________ ◇ **Male** ◇ **Female**

Social Security#: ________________ **Birthdate:** ______________ **Marital Status:** ________________

Address: _____________________________________ **City:** _________________ **Zip:** ___________

Home Phone: ______________________________ **Work Phone:** ______________________________

Cell Phone: ____________________________ **E-mail:** ______________________________________

How would you prefer to be contacted? ____

How did you hear about our office? ____

Employer: ______________________________ **Occupation:** _________________________________

Whom may we contact in the case of an emergency? ____________________ **Phone:** ______________

Dental Insurance

Insurance Company: ___________________________ **Phone #:** ________________________________

Insurance Company Address: ____

City: _______________________________ **State:** ________________ **Zip:** ______________________

Are you the policy holder? ◇Yes ◇ No **If no, what is your relation to the policy holder?** ____________

Policy holder's name: _____________________________________ **Birthdate:** ____________________

Social Security #: ________________________________ **Employer:** ____________________________

Plan ID#: ________________________________ **Group/Plan #:** ____________________________________

Do you have secondary insurance? ◇YES ◇ NO **If yes, please let our administrative team know so that we may gather the necessary information.**

I authorize Austin Dental Spa to release any information acquired in the course of my examination or treatment to my insurance company or other care providers that I have been referred to or from whom I choose to receive care. I authorize that payment be made directly to Austin Dental Spa for services rendered. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account. I have read all the information on this sheet and have verified the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

______________________________________ ________________________

Signature/Parent if minor **Date**

Medical Information

Your current health: ◇GOOD ◇FAIR ◇POOR

Current Physician: ___________________________

Please list any medications that you are currently taking: ______________________________________

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Women:
Are you pregnant? ◇YES ◇ NO Due date: _________
Are you nursing? ◇ YES ◇ NO

Do you have or having ever been treated for any of the following diseases or conditions?

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial joints/bones/valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting spells
Y N Frequent Headaches
Y N Glaucoma
Y N Gum Disease
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV/AIDS
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric problems
Y N Radiation treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sinus Trouble
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease (STD)

Do you smoke or chew tobacco? **◇YES ◇ NO**

Do you need to be pre-medicated for Mitral Valve Prolapse, Heart Murmur, or any kind of joint/bone/valve replacement?

◇YES ◇ NO

Please circle and of the following which you are allergic to:

Aspirin Codeine Dental Anesthetics
Latex Penicillin Erythromycin
Codeine Sulfa Iodine

Please list any other allergies: ___________________

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Dental Information

Previous Dentist: ___________________________
City/State: ________________________________
Last Dental Visit: ____________________________
Current Dental health:◇GOOD ◇FAIR ◇POOR
Are you happy with your smile? ◇YES ◇ NO
If no, please tell us why: ______________________

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Would you like for your teeth to be whiter? **Y N**
Would you like for your teeth to be straighter? **Y N**
Have you had orthodontic treatment? **Y N**
Do you clench or grind your teeth? **Y N**
Do you have pain in your jaw or face? **Y N**
Do you have a bad odor/taste in your mouth? **Y N**
Do your gums bleed when brushing/flossing? **Y N**
Are your teeth sensitive to pressure? **Y N**
Are your teeth sensitive to hot? **Y N**
Are your teeth sensitive to cold? **Y N**
Are your teeth sensitive to sweets? **Y N**
Does food catch between your teeth? **Y N**

Do you have silver or discolored fillings or un-natural looking crowns or bridges that you wished looked different? **Y N** If yes, please explain:

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Please tell us about any other dental concerns that you may have or any information that you feel is important for us know: _________________

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Please tell us what you are looking for in a dental office, what is most important to you? _________

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Please bring this completed form to your appointment or you may fax it to 512-452-5983.

Welcome to Austin Dental Spa!